

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05426					05426				
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>2 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marydel</b> d. STREET ADDRESS <b>R.F.D. Box 60</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Betty Bay Clough</b>					4. DATE OF DEATH Month Day Year <b>April 18 1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/18/66</b>		9. AGE (in years last birthday) yrs. Months Days <b>2 2 25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse Wesley Clough</b>					14. MOTHER'S MAIDEN NAME <b>Suzanne Lola Janson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal Abortion</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity -</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>24 25'</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SO</b>		20f. (City or town) <b>15</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 18 4 AM, 1966</b> , to <b>7 AM, 19 66</b> that (I) (we) last saw the deceased alive on <b>4-18-66</b> , 1966, and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Robert W. Farr</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert W. Farr</b>					22d. ADDRESS <b>Chestertown, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kent &amp; Queen Anne Hosp, Chestertown Md</b>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>R. W. Morin, Administrator</b>					25a. REC'D BY REGISTRAR <b>APR 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05427					05427				
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b> c. LENGTH OF STAY IN 1b <b>50 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pollock Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Davis</b> Last <b>Davis</b>					4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26, 1896</b>		9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired R.R. Cook</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Giles Davis</b>					14. MOTHER'S MAIDEN NAME <b>Febe Ballard</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>198-07-9311</b>		17. INFORMANT <b>Helen Davis Millington, Maryland</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of intestinal tract</b> <b>1539</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Coronary sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>2 years</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4.2</b> , 19 <b>66</b> , to <b>4.4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4.3</b> , 19 <b>66</b> , and that death occurred at <b>6.4</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>GEZA KORALEWSKI</b>					22b. DATE SIGNED <b>4.4-66</b>			22c. PHYSICIAN'S NAME (Type) <b>GEZA KORALEWSKI</b>	
22d. ADDRESS <b>MILLINGTON, MD.</b>					22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rochester Gardens</b>			23d. LOCATION (City, town or county) (State) <b>Ingleside, Maryland</b>		
24. FUNERAL DIRECTOR <b>J. E. Boulaud Greensboro, Md.</b>					25a. REC'D BY REGISTRAR <b>APR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05428

05428

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (rural)</b>		c. LENGTH OF STAY in 1b <b>visitor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fair Hill Farm</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Hepbren</b> Last <b>Gill</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/51</b>
9. AGE (in years last birthday) <b>14</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chestertown (Kent), Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Gill</b>		14. MOTHER'S MAIDEN NAME <b>Frances Long</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <b>Charles H. Gill, Chestertown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Fractured skull</b> <b>9120</b> IMMEDIATE CAUSE (a) DUE TO <b>Tractor accident.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Deceased was between a tractor &amp; fodder wagon</b> (c) <b>hooking wagon to drawbar. Tractor backed further &amp; intended by Robert Fry, driver. He was struck by</b>		INTERVAL BETWEEN ONSET AND DEATH <b>short</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>power take-off shaft producing the injury noted above.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>see above</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:45xx 4/9/66</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Fair Hill Farm</b>		20f. (City or town) (County) (State) <b>Chestertown Kent Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>4/11/66</b>		ACTUAL SIGNATURE <b>Robert W. Farr, M. D.</b> EXAMINER'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown Kent Md.</b>	
24. FUNERAL DIRECTOR <b>Marvin V. Williams</b>		ADDRESS <b>Chestertown, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05429

05429

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN life <b>Adult</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne (15 days)</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown adult life</b> d. STREET ADDRESS <b>111 Maple Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lulu K. Harley</b>		4. DATE OF DEATH <b>Apr. 29, 1966</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/31/1887</b>		9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Q. A. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Walton Harley</b>				14. MOTHER'S MAIDEN NAME <b>Lulu Kibler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 48 0182</b>		17. INFORMANT Address <b>Hospital Records Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> 4221 DUE TO (b) <b>A.S.C.U.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Advanced age</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/14/66</b> , 19 <b>66</b> , to <b>4/29/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-29</b> 19 <b>66</b> , and that death occurred at <b>3:15</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Harry Paul Ross</b>				22b. DATE SIGNED <b>4/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Harry Paul Ross</b>	
22d. ADDRESS <b>Chestertown, Md.</b>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>				25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05430

05430

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Joseph</b> Last <b>Jennings</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-01</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>2</b>	11. IF UNDER 24 HRS. Hours <b>17</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vita Food</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor (Elec.)</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Joseph Jennings (D)</b>		14. MOTHER'S MAIDEN NAME <b>Florence Reathman (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-3587</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carcinoma of Rectum</b> DUE TO (c) <b>unk</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-17</b> , 19 <b>66</b> , to <b>4-3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-3</b> , 19 <b>66</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Arthur T. Keefe</b> M.D.		22b. DATE SIGNED <b>4-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Arthur T. Keefe</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>
24. FUNERAL DIRECTOR <b>J. S. Silbo Wells</b>		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
05431  
CERTIFICATE OF DEATH

05431

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millington</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Linda Catherine LaPorte</b>		First <b>Linda</b>		Middle <b>Catherine</b>		Last <b>LaPorte</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-18-13</b>		9. AGE (in years last birthday) <b>53</b> yrs.		10. UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Alfred Thomas Foraker M (D)</b>						14. MOTHER'S MAIDEN NAME <b>Linda Frances McNatt (L)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-32-7169</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post-operative Complications</b> <b>545X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subtotal Sarcoid Resection</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-24-</b> , 19 <b>66</b> , to <b>4-11-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-11-</b> , 19 <b>66</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Arthur T. Keefe</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Arthur T. Keefe</b>						22d. ADDRESS <b>Chestertown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April, 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Millington Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Millington, Kent Co; Md.</b>			
24. FUNERAL DIRECTOR <b>Edward Fellows</b>						ADDRESS <b>Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



## CERTIFICATE OF DEATH

05432

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		d. STREET ADDRESS <b>307 Washington Avenue/</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frederick George Livingood, Sr.</b>		4. DATE OF DEATH Month Day Year <b>April 25 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-1893</b>
9. AGE (n years lost birthday) <b>72 yrs</b>		10. IF UNDER 1 YEAR Months Days <b>14 days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired College Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jefferson Co. Penna.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Kline Livingood (D)</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Marguerite Schaeffer (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-0974</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Complications following operation for</b> DUE TO <b>adenocarcinoma of rectosigmoid</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <b>Malignant tumor of large intestine</b> DUE TO <b>Malignant tumor of large intestine</b> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-29</b> , 19 <b>66</b> , to <b>4-25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-25</b> , 19 <b>66</b> , and that death occurred at <b>6:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. A. C. Dick</b>		22b. DATE SIGNED <b>4-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. C. Dick</b>		22d. ADDRESS <b>Chestertown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/28/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Myerstown, Penna.</b>
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>		25a. REC'D BY REGISTRAR <b>APR 28 1966</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHURCH HILL</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KENT &amp; QUEEN ANNE Co.</b>						e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERNEST JAMES ROTHWELL</b>						4. DATE OF DEATH Month Day Year <b>APRIL 18 1966</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 8 - 1894</b>		9. AGE (in years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE SHOP QUEEN ANNE Co. MD</b>		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ARTHUR B. ROTHWELL</b>						14. MOTHER'S MAIDEN NAME <b>ELIZABETH COWELL</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>215-36-8735A</b>		17. INFORMANT <b>ALFRED ROTHWELL - CENTREVILLE MD.</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-23</b> , 19 <b>63</b> , to <b>4-18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-18</b> , 19 <b>66</b> , and that death occurred at <b>9:20</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Harry Paul Ross</b>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-24-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS</b>						22d. ADDRESS <b>203 N Queen, CHESTERTOWN, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 21</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESTERFIELD</b>		23d. LOCATION (City, town or county) (State) <b>CENTREVILLE MD.</b>					
24. FUNERAL DIRECTOR <b>Edgar L. Lane - CHURCH HILL MD.</b>						25a. REC'D BY REGISTRAR <b>APR 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05434

05434

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>5 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Rock Hall</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Shirley Elizabeth Sisco</b>				4. DATE OF DEATH Month Day Year <b>4 29 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-31-35</b>	
9. AGE (In years last birthday) <b>30 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>30</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Randolph Sisco</b>				14. MOTHER'S MAIDEN NAME <b>Mozella Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Air embolism</b> 754 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Under anesthesia for laparotomy 3 hrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>O. S. Gulbrandsen</i>				22. DATE SIGNED <b>5-2-66</b>			
EXAMINER'S NAME (Type) <b>O. S. Gulbrandsen, M.D.</b>				Address (Street, city, town, or county) <b>Rock Hall, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHERRTOWN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall, Md</b>	
24. FUNERAL DIRECTOR <b>Benjamin D. W. Chastertown</b>				25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>			
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton</b> c. LENGTH OF STAY IN 1b <b>adult life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Irving F.</b> Middle <b>Smith</b> Last			4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1966</b>						
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/1897</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>68</b> Days	IF UNDER 24 HRS. Hours <b>68</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cattle Buyer Dealer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>John C. Smith</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. Taylor</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>218 16 5200</b>		17. INFORMANT <b>Mrs. Mabel Smith Worton, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia left lower lobe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Upper respiratory infection</b> (b) <b>Due to</b> (c) <b>Due to</b>								INTERVAL BETWEEN ONSET AND DEATH <b>several days</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/66</b> to <b>4/2/66</b> , that (I) (we) last saw the deceased alive on <b>4/2/66</b> 19 <b>66</b> , and that death occurred at <b>11 P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert W. Farr</b>					22b. DATE SIGNED <b>4/2/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>					22d. ADDRESS <b>Chestertown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chestertown Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>		
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>					25a. REC'D BY REGISTRAR <b>APR 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		





## CERTIFICATE OF DEATH

05430

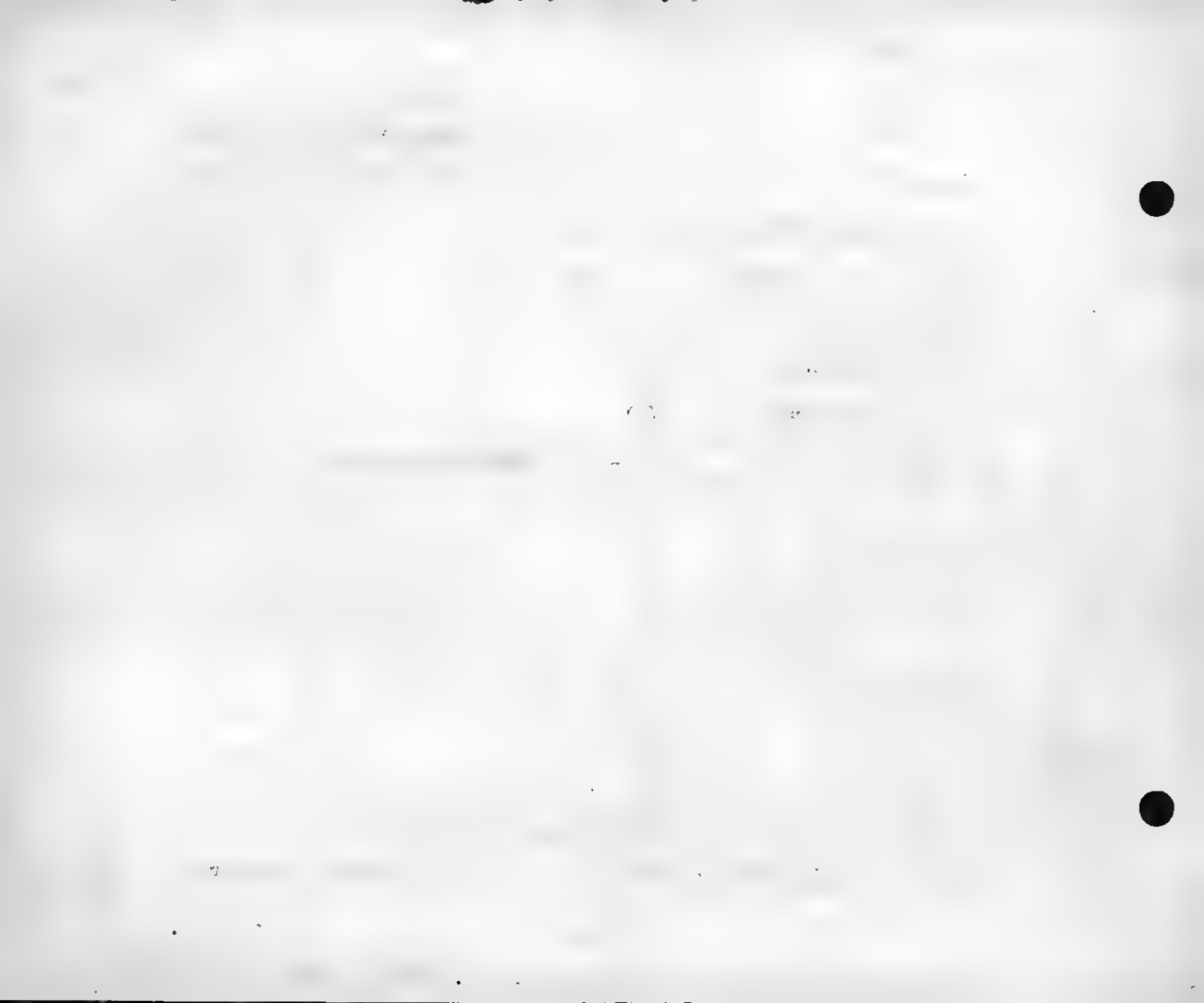
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 15 <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Wesley</b> Last <b>Stevens</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-80</b>
9. AGE (In years last birthday) <b>85</b> yrs		10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wesley Stevens (D)</b>	
14. MOTHER'S MAIDEN NAME <b>Emily Ashley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>218-18-7778A</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardium of heart</b> 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/5/1966</b> , to <b>4/21/1966</b> , that (I) (we) last saw the deceased alive on <b>4/21/1966</b> , and that death occurred at <b>1:30 p.m.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Harry P. Ross</b>	22b. DATE SIGNED <b>4/21/1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Harry P. Ross</b>
22d. ADDRESS <b>Chestertown, Maryland</b>		22e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 24</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>	23d. LOCATION (City or Town) (County) (State) <b>Rock Hall Md.</b>
24. FUNERAL DIRECTOR <b>Edgar L. Lane</b>		25. REC'D BY REGISTRAR <b>APR 28 1966</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66



1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05437

05437

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, Md.</b>			
c. LENGTH OF STAY IN 1b <b>2 years</b>				d. STREET ADDRESS <b>220 Lynchburg St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Thomas</b>				4. DATE OF DEATH Month Day Year <b>4 28 19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-15-06</b>	
9. AGE (in years last birthday) <b>59 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Myrtle Butler - Rock Hall, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung abscess</b> 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Previous tuberculosis, quiescent 0072</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>1 week</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>9</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>5-2-66</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-2-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharptown Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Rock Hall, Md.</b>		24. FUNERAL DIRECTOR <b>James H. Wally</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05438 CERTIFICATE OF DEATH 05438											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Rural)				c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Rural 14-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairlee						d. STREET ADDRESS Fairlee				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tilden B. Willson						4. DATE OF DEATH Month Day Year Apr. 14, 1966 19					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1897 68		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Grain & feed mill				10b. KIND OF BUSINESS OR INDUSTRY Grain & feed mill		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Neal Willson						14. MOTHER'S MAIDEN NAME Alice Sappington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218 20 8154		17. INFORMANT Address (Fairlee) Hester Willson Chestertown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 18, 1954, to April 14, 1966, that (I) (we) last saw the deceased alive on April 14, 1966, and that death occurred at 11:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Norbert C. Nitsch						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/15/66			
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch						22d. ADDRESS Rock Hall, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/17/66		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.			23d. LOCATION (City, town or county) (State) nr. Chestertown, Md.		
24. FUNERAL DIRECTOR J. Wells Wells						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE APR 18 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*